VIRGINIA DEPARTMENT OF HEALTH
CRITERIA AND APPLICATION PROCEDURES FOR STATE FUNDING OF CERTAIN ABORTIONS

I. THE CODE OF VIRGINIA, STATED BELOW, AUTHORIZES STATE FUNDING OF CERTAIN ABORTIONS.

§ 32.1-92.1. Funding of certain abortions where pregnancy results from rape or incest.

From the moneys appropriated to the Department from the general fund, the Board shall fund abortions for women who otherwise meet the financial eligibility criteria of the State Medical Assistance Plan in any case in which a pregnancy occurs as a result of rape or incest and which is reported to a law-enforcement or public health agency.

§ 32.1-92.2. Funding of certain abortions where fetus is believed to have incapacitating physical deformity or mental deficiency; physician's certificate.

From the moneys appropriated to the Department from the general fund, the Board shall fund abortions for women who otherwise meet the financial eligibility criteria of the State Medical Assistance Plan in any case in which a physician who is trained and qualified to perform such tests certifies in writing, after appropriate tests have been performed, that he believes the fetus will be born with a gross and totally incapacitating physical deformity or with a gross and totally incapacitating mental deficiency.

II. BASIC REQUIREMENTS

A. The applicant must be a resident of the Commonwealth of Virginia.
B. The applicant must meet the financial eligibility criteria of the Virginia Department of Medical Assistance Services Plan.
C. The applicant must report the incident of rape or incest to law enforcement or a public health agency. A “public health agency” as used herein shall be defined as the Virginia Department of Health (VDH). According to Virginia law, all physicians must report cases of alleged sexual assault of children under eighteen to the Child Abuse Hotline of the local Department of Social Services; or
D. The applicant’s physician shall have performed appropriate tests and certifies that he believes that the fetus would be born with a gross and totally incapacitating physical deformity or a totally incapacitating mental deficiency. Copies of cited evidence, such a sonogram report(s) and genetic studies, must accompany the application.

III. THE APPLICATION PROCESS

A. The individual makes application for funds for an abortion under this program with the diagnosing physician, facility that will perform the abortion or local health department. The Application Form attached shall be used for this purpose.
B. If the applicant is not currently enrolled in the Medicaid Program, the applicant will contact the Department of Social Services (DSS) to assure that she is

Medicaid eligible. DSS must provide evidence of her eligibility. This information must be provided with the completed application.

C. Those applicants who are currently enrolled in the Medicaid Program shall be considered eligible for this Program. No further financial eligibility interviews are required.

D. Participation with Virginia's Plan First will not meet the financial requirements.

IV. THE APPROVAL PROCESS FOR ABORTIONS RESULTING FROM RAPE OR INCEST

A. Upon confirmation of financial eligibility, the physician's office, facility or local health department will fax the application form, confirmation of financial eligibility or a copy of applicant's Medicaid card to VDH/Division of Women's and Infants' Health (DWIH) at 804-864-7771.

B. Telephone DWIH at 804-864-7772 to confirm arrangements.

C. The Director of DWIH will review, sign and fax an approved application form back to the originator.

D. Originator will provide the form to the applicant with instructions to take the form to the provider of the termination.

V. THE APPROVAL PROCESS FOR ABORTIONS FOR FETAL ABNORMALITY

A. The referring physician shall fax the application to DWIH at 804-864-7771. Upon receipt of the application, the Director of the Office of Family Health Services shall review the application for completeness and medical necessity. In addition, review shall be conducted at least one other physician.

B. The review shall be accomplished within 24 hours of receipt of a completed application packet.

C. The Director of the Office of Family Health Services will check "Approved for Fetal Abnormality Termination" or "Not Approved" and sign the application in the space provided. DWIH will inform the referring physician's office of review results.

D. Reviewing physician will be available to discuss a case if the referring physician desires.

E. It is the responsibility of the referring physician's office to notify the patient of the denial or approval of the application.

VI. APPROVED APPLICATION FORMS SHALL BE DISTRIBUTED AS FOLLOWS

A. One copy of the application form, along with a copy of the financial eligibility forms or a copy of the applicant's Medicaid card, shall be forwarded to Virginia Department of Health, DWIH

B. One copy of the application shall be retained at the referring physician's office

C. One copy of the application is provided to the patient to be taken to the facility performing the termination.

VII. **THE PAYMENT PROCESS**

A. The facility performing the abortion must submit the bill, using the Health Insurance Claim form (CMS 1500), directly to the Division of Women's and Infants' Health for payment. Billing codes must reflect the procedures performed. Payment shall be limited to the Medicaid allowance for the procedure. **THE APPROVED APPLICATION FORM MUST BE ATTACHED TO THE BILL.**

APPLICATION FOR VDH FUNDED TERMINIATION UNDER SECTIONS 32.1-92.1 and 32.1-92.2 of CODE OF VIRGINIA (1950), AS AMENDED

DATE OF APPLICATION: _____

NAME OF APPLICANT: _____

ADDRESS OF APPLICIANT: _____

COUNTY/CITY OF RESIDENCE: _____ **NAME AND ADDRESS OF FACILITY TO PERFORM THE PROCEDURE:**

_____

BIRTHDATE: _____

_____

"I hereby request State funds under the provisions of Section 32.1-92.1 and 32.1-92.2 of the Code of Virginia (1950), as amended. I certify that this pregnancy is the direct result of:

☐ **RAPE** ☐ **INCEST**	☐ **FETAL ABNORMALITY TERMINATION**
DATE OF OCCURRENCE: _____ REPORTED TO: _____ DATE REPORTED: _____	ATTACH ALL DIAGNOSTIC PROCEDURE RESULTS: ☐ AMNIOCENTESIS ☐ ULTRASOUND ☐ BLOOD TEST ☐ OTHER
DATE _____ _____ APPLICANT'S SIGNATURE _____ PARENT'S SIGNATURE, IF APPLICANT IS UNEMANCIPATED MINOR	SUMMARY OF DIAGNOSTIC PROCEDURE RESULTS: ☐ Approved ☐ Not Approved Rationale:_____ _____ _____ _____ Director, Office of Family Health Services _____ Concurring Physician ☐ Referring Physician notified

"I certify that my examination of the applicant and/or her medical record indicates that she is _____ weeks pregnant as of _____." **_____**

DATE **ATTENDING PHYSICIAN**

Acknowledgement: "The Virginia Department of Health guarantees payment to the facility named in the application for performing an abortion on the individual named herein as the 'Applicant'. Such payment shall be limited to the usual reimbursement rate established by the Virginia Medical Assistance Program (Medicaid), and shall constitute full and final payment for such services."

_____
Director, Division of Women's and Infants' Health

Fax application to: (804) 864-7771
Submit bills to: Director, Division of Women's & Infants' Health
Virginia Department of Health
P. O. Box 2448, 8th FL.,
Richmond, Virginia 23218

PATIENT INFORMATION CHECKLIST TO ASSIST IN THE DETERMINATION OF MEDICAID FINANCIAL ELIGIBILITY

- **To quickly process your application, please do the following:**
  - Make an appointment with local Department of Social Services to see if you meet financial requirements
  - Please refer to the Medicaid website for a complete list of requirements:
    www.dmas.**virginia**.gov/rcp-home.htm

- **Take with you to the appointment:**

1. A list of all people living with you. Include their age and relationship to you.

2. You must disclose all income you receive. Pay stubs, Social Security, veteran's benefits, child support, letters from employers or other documents which will show what each person living with you earns when you go for the interview.

3. Any documents that will show what pensions, annuities, grants-in-aid, dividends and/or interest income are received by each person living with you.

4. Bring your latest bank statements and/or bank books which document your bank accounts.

5. Verification of Life Insurance policies – life insurance policy, etc.

6. A statement of any cash on hand.

7. Verification of the value of automobile(s) – tax records, loan records, etc.

8. Verification of other personal property (except personal effects, household furnishings), a statement of the type and value of personal property owned and, if possible a statement from someone with knowledge of that type of property. For example, a stockbroker could verify the value of stocks and bonds.

9. Real Property – a statement of any real property owned other than your home and lot. Verification of this property must be provided. Verification could be provided by tax records or the statement of the Commissioner of Revenue of the locality.